covery and (3) the general condition of the patient together with the character and time of the treatment. The treatment is outlined as follows: The appendix should be removed, the infected lymphatics leading from the appendix to the liver should be incised and drained, and the liver should be exposed and the abscesses located and drained. The abscess or abscesses in the lung must be located and drained. The intense pain will frequently guide the surgeon to the site of the abscesses. Babler does not feel that it is advisable to aspirate the liver until the latter has been duly exposed, unless preparations for immediate intervention have been completed. He strongly supports the lumbar drain in these cases.

The "Tongue-Depressor" Gastro-enterostomy Clamp.—GIBSON (*Ann. Surg.*, 1915, lxi, 604) illustrates a very simple clamp for gastric and intestinal anastomoses, consisting of three small pieces of wood, the ordinary wooden tongue-depressors, which are bound together by any suitable method, such as strong artery clamp, or, if more convenient, a sterile rubber band. These might be replaced by strips of cigar boxes. In his hands, both in experimental and clinical work, it has proven much more satisfactory than the Roosevelt, Bartlett, and other clamps used for this purpose. He has found it particularly satisfactory in doing a gastro-enterostomy, when it is desired to release the clamp in putting in the last mucous suture and the final peritoneal suture. Removing the rubber band allowed the tongue depressors to fall apart without further manipulation. By this method injury to the viscera is less likely to be produced. Two gastro-enterostomies and one entero-anastomosis have been successfully done with the aid of these clamps.

The Bone Graft Peg in the Treatment of Fractures of the Neck of the Femur.—ALBEE (*Ann. Surg.*, 1915, lxii, 85) says a large number of these fractures occur in individuals below the age of forty-five and fifty. The terms intracapsular and extracapsular are inaccurate and misleading and there is no object in classifying these fractures further than by the single term, "fractures of the neck." If any classification is used that of Stimson is by all means the best, *i. e.*, subcapital, or fracture through the neck, and fracture at the base of the neck. A strong autogenous bone peg, accurately fitted into a hole drilled longitudinally through the neck of the femur, with the fragments in good position, offers unquestionably the most ideal condition for the rapid and satisfactory union, in good position, of this fracture. The technic of the operation is as follows: The patient should be placed upon some traction table (Hawley) which will allow, simultaneously, abduction and traction. The point of the fracture is reached by an incision starting from a finger's breadth inside of the anterior superior spine and curved downward three to five inches along the inner border of the sartorius, which is retracted outward. The rectus femoris is retracted outward and the iliopsoas inward. All soft tissue is then cleared from between the fractured ends, which are curetted and freshened. The limb is now abducted and sufficient traction applied to bring the fragments into good apposition as determined by both sight and touch through the anterior wound. An incision two to three inches long is then made over and just beyond the great trochanter which is exposed. With a small hand drill the proper direction for the motor drill is determined by trial, as shown by observation through both wounds, the hole passing parallel to and through the centre of both fragments. The motor drill should be held ready for insertion into the tract of the hand drill as it is withdrawn by the assistant. The motor drill, which forms a hole three-eighths of an inch in diameter, is pushed through the distal fragment until the burr end of the drill appears between the fragments, as seen through the anterior wound. Just as the end of the drill is engaging the broken end of the proximal surface, a reading on the graduated drill shaft is taken at its entrance aperture in the trochanter, so that by making additional readings it can be determined how deep the capital fragment is being penetrated. By studying the roentgenogram, the length of this fragment can be very accurately determined, and hence the desired depth of the drill-hole obtained. When the fracture has occurred near the head and the proxinal fragment is consequently short, the drill-hole should extend close to the articular cartilage of the head. The drill is disengaged from the motor and left in place, to avoid any possible displacement of the fragments while the tibial graft is being procured. The crest of the lower portion of the tibia is laid bare, and an area of the desired shape and size is mapped out in the periosteum with a scalpel. The desired length of graft can be determined by the graduated scale on the motor drill. The cross section of the graft should be just large enough to be shaped into the peg when the dowel shaper is used. When the graft peg is ready, the drill is withdrawn from the femur and the peg inserted. The fit must be accurate because the dowel cutter is the counterpart of the drill used. The accuracy of fit is very important. Too tight a fit causes a pressure anemia of the surrounding cancellous bone. Too loose a fit, or an irregular, inaccurate fit, would not produce good fixation or favor an immediate bony union of graft to the host fragments. The deep fasciæ are approximated with interrupted sutures of No. 2 chromic catgut. The skin wound is closed with continuous suture of No. 1 chromic catgut. The limb is placed in abduction (Whitman) in a plaster-of-Paris spica extending from the toes to the axilla. Three weeks after the operation, windows are cut in the plaster, and the wounds dressed. The dressing should be replaced with cotton for the purpose of restoring the tension of the cast and retaining the fixation. The long spica should be continued for six weeks and followed by a short one for six weeks longer.

Cryptogenetic Peritonitis with Special Reference to the Mode of Infection of the Peritoneum.—BRUNZEL (*Deutsch. Ztschr. f. Chir.*, 1915, cxxiii, 233) says that an advance was made with the discovery of the Fränkel-Weichselbaum pneumococcus and the designation of these so-called spontaneous or idiopathic cases of peritonitis according to this, apparently, most common cause. But the new name, "pneumococcus-peritonitis," did not throw light on the mode of infection of the peritoneum. Other bacteria may be at fault as the streptococci and staphylococci. The term, cryptogenetic, is used here to designate those cases of peritonitis in which the cause is unknown or not definitely